MAPLE DENTAL CARE
Khai D. Vu, D.D.S.
301 Maple Avenue W., Ste. 140
Vienna, VA 22180
703-938-0559

Patient Information

Last Name: _____ First Name: _____ Preferred Name: _____

Middle Name: _____ Title: Mr. / Mrs. / Ms. / Dr. Home Number: _____

Home Address: _____ Work Number:

City: _____ State: _____ Zip Code: _____ Cell Number: _____

Social Security #: _____ Date of Birth: _____ Sex: Male / Female

Marital Status: Single / Married / Divorced / Widowed. Whom may we personally thank for referring you:

Employer / School: _____ Email Address: _____

MEDICAL / DENTAL INFORMATION

Are you under any medical treatment now? Yes / No Explain if yes: _____
Physicians Name and number if under medical treatment: _____
Are you taking ***any*** daily medication? Yes / No List if any: _____

Are you allergic to or do you suffer ill effects from any of the following?

Y / N	Y / N	Y / N
☐ ☐ Penicillin	☐ ☐ Sulfa	☐ ☐ Dental Anesthesia
☐ ☐ Amoxicillin	☐ ☐ Latex	☐ ☐ Other Medications:

Do you have a history of:

Y / N	Y / N	Y / N
☐ ☐ Heart disease or Stroke	☐ ☐ Kidney disease	☐ ☐ Sinus trouble
☐ ☐ High or Low blood pressure	☐ ☐ Anemia or bleeding problems	☐ ☐ Thyroid or Endocrine disorder
☐ ☐ Rheumatic fever	☐ ☐ Liver disease	☐ ☐ Radiation or Chemotherapy
☐ ☐ Heart murmur, Prolapsed valve	☐ ☐ AIDS of HIV infection	☐ ☐ Fainting spells or Seizures
☐ ☐ Prosthetic Joint replacement (hips, valves, shunts, pins, plates)	☐ ☐ Chemical dependency	☐ ☐ Breathing problems
	☐ ☐ Tuberculosis or Lung disease	☐ ☐ Asthma or Emphysema
☐ ☐ Diabetes	☐ ☐ Arthritis or Rheumatism	☐ ☐ Do you smoke or chew tobacco
☐ ☐ Hypoglycemia	☐ ☐ Environmental allergies	☐ ☐ Other:

For Women only: *Are you pregnant? ___Y_____N If yes, How far are you in your pregnancy? _____
*Do you take Bisphosphonate drugs (Actonel, Fosamax....)? ____Y_____N

- Do you have a dental problem now? ☐Yes ☐No Explain if yes:
- Do you have or have you been treated for TMJ problems? ☐Yes ☐No
- Do you clench or grind your teeth? ☐Yes ☐No
- Do you wear a splint or mouth guard? ☐Yes ☐No
- Are any of your teeth sensitive to hot, cold, or sweets? ☐Yes ☐No
- Have you had gum treatment or surgery? ☐Yes ☐No
- Are you happy with the appearance of your teeth? ☐Yes ☐No
- Do you have any specific questions you would like to discuss? ☐Yes ☐No Explain if yes: _____
- When was you last dental visit? _____ And for what reason did you seek dental care? _____
- How often do you brush your teeth each day? ☐1-2 times ☐2-3 times ☐3+ times
- How often do you floss? ☐Daily ☐Weekly ☐Infrequently
- How often and with what do you rinse with? _____

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

_____ _____ _____
Patient/Parent Signature Dentist's Signature Date

Dental Insurance Information(Subscriber's Information)

Subscriber's Name:_____Relationship to Patient:_____
Last First MI

Home Address:_____
Street City State ZipCode

Date of Birth:_____Social Security#:_____ID#:_____ Group#:_____

Employer/Company Name:_____Insurance Company:_____

Insurance Address:_____

Person Responsible for Account

Name:_____Relationship to Patient:_____
Last First MI

Home Address:_____
Street City State ZipCode

Date of Birth:_____Social Security#:_____Home #:_____Cell#:_____

NOTICE FOR PATIENTS WITH INSURANCE: Please understand that your dental insurance is a contract between your insurance and only you. We verify your insurance, estimate your co-pay, and file your claims to your insurance as a courtesy to our patients. We can not guarantee what your insurance will pay. We estimate your copayment based on information given from your insurance; hence, we can not responsible for any errors in estimating. We will refer to your insurance's statement for the final charges.

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid in full at the time services are performed. ***There is a charge of $30 for any broken appointment, or cancellation less than 24 hours notice. We only accept checks from our good financial standing patients who have established a good history with us. A $30 fee also is applied for any returned check.***

I certified that I, and/or my dependent(s), have insurance coverage with my above-mentioned insurance company (ies) and assign directly to Khai D. Vu, D.D.S. all insurances, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Khai D. Vu, D.D.S. may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

A finance charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements were made. A service fee of 30-50% will also be charged on delinquent accounts sent to the Collection Agency.

I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of services to the Doctor, or his assignee, at the time the services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of services will be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder will not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.
I have read the above conditions of treatment and payment and agree to their content..

_____ _____ _____
Signature of Patient, Parent or Guardian Date Relationship to Patient

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NOTICE OF PRIVACY ACT PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY AS THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualification of healthcare professional, evaluating practitioner and provider performance, conduction training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health in information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will ***not*** use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or national security activities.

Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcard, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, a fee may be charged to relocate copies of your information.

Amendment: You have the right to request that we amend your health information.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices, or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternate means or at alternate locations, you may complain to the contact information listed at the end of this Notice.

You also may submit a written complaint to the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in anyway if you choose to file a complaint with us to the Department of Health and Human Services.

I HAVE READ AND CONSENT TO THE USE AND DISCLOSURE OF MY PERSONAL HEALTH INFORMATION BY YOUR OFFICE DURING TREATMENT, BILLING/PAYMENT AND DENTAL OFFICE OPERATIONS AS OUTLINED IN THE NOTICE OF PRIVACY PRACTICES.

_____ _____

Signature of Patient, Parent, or Guardian Date